

- b. _____ disabled
c. _____ aged and disabled
d. _____ mentally retarded
e. _____ developmentally disabled
f. X mentally retarded and
 developmentally disabled
g. _____ chronically mentally ill
4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):
- a. _____ Waiver services are limited to the following age groups (specify):
b. _____ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):
c. _____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.
d. X **Other criteria. (Specify):**
An eligible individual has a place to live in the community, typically with family. Unpaid caregivers/family will provide a substantial amount of care. However, the individual requires services and supports in scope or intensity beyond what the primary caregiver(s) are able to provide all 24-hours in a day and/or every day of the year. The caregiver's inability to meet all service and support needs, puts the individual at risk of out of home placement in an ICF/MR.
e. _____ Not applicable.
5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.
6. This waiver program includes individuals who are eligible under medically needy groups.
- a. _____ Yes b. X No
7. A waiver of §1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.

a. _____ Yes b. _____ No c. X N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

a. X Yes b. _____ No

Missouri will refuse to offer home and community-based services to any applicant whose cost for services through the waiver will exceed the average cost of all levels of ICF/MR institutional care. The cost comparison will be made to the State's average annual per capita cost for all persons served in all ICFs/MR.

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

a. _____ Yes b. X No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

a. X Yes b. _____ No

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

- a. No Case management
- b. No Homemaker
- c. No Home health aide services
- d. Yes Personal care services (**Personal assistant**)
- e. Yes Respite care (**In-home & Out of home**)
- f. No Adult day health

19. An effective date of July 1, 2003 is requested.
20. The State contact person for this request is Sandra Levels, who can be reached by telephone at (573) 751-6926.
21. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by HCFA, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: _____

Print Name: Steve Roling

Title: Director, Dept. of Social Services

Date: _____

Relation to State Plan Services

When an individual's need for personal assistance is strictly related to ADLs and can be met through the Medicaid state plan personal care program, he or she will not be eligible for personal assistant services under the waiver, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. However, personal care services under the state plan differ in service definition, in limitations of amount and scope, and in provider type and requirements from personal assistant services under the waiver.

Personal assistant service, in any combination of individual, group, consumer directed, or agency based, is limited to \$17,000 per year per person. Any combination of personal assistant services with day habilitation, respite, crisis intervention, community specialist, communication skills instruction, counseling, environmental accessibility adaptations, specialized medical equipment and supplies, therapies, transportation and supported employment through the waiver shall be limited to \$20,000.

Provider Qualifications

Provider qualifications are specified in Appendix B-2. Personal assistance may be provided either by an individual worker employed by the consumer or family or by an employee of an agency. The determination of which type of provider will deliver the service will be the choice of the consumer and/or his family or guardian, with the limitation that for an individual provider to be used, the consumer and/or family or guardian must be able and willing to supervise the provider and the planning team must certify that this supervision will be sufficient to safeguard the individual's health and safety.

Provider Supervision

Supervision will be provided by a QMRP or by the consumer or his or her family or guardian. In either case, the frequency and scope of the supervision will be specified in the plan of care. Refer to Personal Assistant Services in the addendum to Appendix B-2.

Relatives as Providers

Personal assistant services provided to a person by a member(s) of his or her immediate family (natural, half-, or step- relationships with parent, child, sibling, spouse) may not be reimbursed under the waiver. Other persons related to the consumer may provide this service under the waiver if they meet the same age and training requirements as other providers. There must be a determination by the planning team, documented in the person's plan, that such an arrangement will best meet the particular needs of the

Non-Duplication of Services

Personal assistance is not available to waiver consumers who reside in community residential facilities (Group Homes and Residential Care Centers) or who receive Individualized Supported Living (ISL) services, when the personal assistant services would duplicate the residential habilitation services being provided under those models. Exceptions may be approved by the regional center when the planning team can show the need and efficiency of combining these services and can document that no duplication of payment would result.

e. Yes **Respite care:**

X Other service definition (Specify):

Respite care is separated into those services provided in the home and community and those services provided out of the home as described below.

Respite care, in any combination of in-home or out-of home, is limited to \$15,000 per year per person. Any combination of respite care with personal assistant, day habilitation, crisis intervention, community specialist, communication skills instruction, counseling, environmental accessibility adaptations, specialized medical equipment and supplies, therapies, transportation and supported employment through the waiver shall be limited to \$20,000.

In-Home Respite

In-Home Respite is provided to individuals unable to care for themselves, on a short-term basis, because of the absence or need for relief of those persons normally providing the care. To be eligible for in-home respite care, the persons who normally provide care to the individual must be other than formal, paid caregivers. This service will not be delivered in lieu of day care for children nor will it take the place of day habilitation programming for adults. While ordinarily provided on a one-to-one basis, in-home respite may include assisting up to three individuals at a time.

A unit of service is one hour or one day. Total hours provided must be necessary to avoid institutionalization and remain within the overall cost effectiveness of each individual's plan. The service is provided in the individual's place of residence, at a qualified day program site, or elsewhere in the community **excluding an institution**. If the service includes overnight care, it must be provided in the individual's place of residence.

Provider Qualifications

In-home respite may be provided either by an individual provider or by an employee of an agency. The determination of which type of provider will deliver the service will be the choice of the individual and/or his family or guardian, with the limitation that for an individual provider to be

used, the individual consumer and/or family or guardian must be able and willing to supervise the provider and the planning team must certify that this supervision will be sufficient to safeguard the individual consumer's health and safety.

Provider Supervision

Supervision will be provided by a QMRP or by the consumer or his or her family or guardian. In either case, the frequency and scope of the supervision will be specified in the plan of care. Refer to In-Home Respite Services in the addendum to Appendix B-2.

Relatives as Providers

In-home respite services provided to a person by a member(s) of his or her immediate family (defined as natural, half-, or step- relationships with parent, child, sibling living with the consumer, or spouse) may not be reimbursed under the waiver. Other persons related to the individual may provide this service under the waiver if they meet the same age and training requirements as other providers. There must be a determination by the planning team, documented in the person's plan, that such an arrangement will best meet the particular needs of the individual.

Out of Home Respite

Out of Home Respite is temporary care provided outside the home in a licensed, accredited or certified Waiver Residential Facility, ICF-MR or State Habilitation Center for a period of no less than one day (24 hours) by trained, qualified personnel, on an intermittent basis. The purpose of respite care is to provide temporary relief to the customary caregiver. There is no annual limit to the days of out-of-home respite so long as the service is cost effective when combined with all other waiver and state plan community-based services provided to the individual.

FFP is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

- f. No **Adult day health:**
g. Yes **Habilitation:**

X **Other service definitions follow for Day Habilitation and Supported Employment.**

Day habilitation services are provided to enable individuals to achieve their optimal physical, emotional, and intellectual functioning. Day habilitation may include training, coordination and intervention to enable and increase independent functioning, physical health and development, language development, cognitive training, socialization, community integration, domestic and economic management, behavior management, responsibility and self direction. Training activities may include consumers and their families; coordination activities necessary to implement the person-centered plan may include family, professionals and others involved with the individual, as

directed by the planning team.

Services may be provided at the day program site or in the consumer's own home or community, and they may be provided individually or in small groups. The planning team determines the content, site(s) and mode(s) of learning which best meet the needs of each individual. The planning team also assures that day habilitative services are coordinated with any therapies the person requires and that the day habilitative services do not duplicate, nor are duplicated by, any other habilitative services authorized for the individual.

All service units are 1/4 hour. Day habilitation services may not include vocational, pre-vocational and educational services and individuals may not earn income as part of participation in this service. Transportation costs for community integration activities are included in the unit rate for day habilitation, but costs for transporting consumers from and to their residences are not included.

Day habilitation services, in any combination of on-site group or individual or off-site group or individual, is limited to \$17,000 per year per person. Any combination of day habilitation services with respite care, personal assistant, crisis intervention, community specialist, communication skills instruction, counseling, environmental accessibility adaptations, specialized medical equipment and supplies, therapies, transportation and supported employment through the waiver shall be limited to \$20,000.

X **Supported Employment**

Supported employment is competitive work in an integrated work setting with on-going support services for individuals with severe disabilities for whom competitive employment either has never been possible or has been interrupted as a result of the disability. The service must be based on a supported employment assessment and must be prescribed in a person centered plan. A unit of service is 1/4 hour. Supported employment is a cost effective alternative to placement in an ICF-MR.

In the context of supported employment, competitive work is defined as a full or half time job, for which the individual is paid in accordance with the Fair Labor Standards Act. An integrated work setting is one in which workers with disabilities are, to the greatest extent possible, integrated with persons who do not have disabilities. Ongoing support consists of continuous or periodic job skill training provided at least twice monthly at the work site to enable the individual to perform the work. Models of supported employment will include job coach, enclave (a cluster of jobs in an integrated setting, such as a plant), and mobile crew.

Supported Employment services may be provided one-on-one or to groups of individuals and may include:

- Individualized assessment;
- Individual job counseling;
- Individualized job development and placement

- On-the-job training in work and work-related skills;
- Ongoing supervision and monitoring of the person's performance on the job; and
- Training in related skills needed to obtain and retain employment such as using community resources and public transportation. Transportation costs are not included in the supported employment fee, but specialized transportation is available as a separate service if necessary.

The waiver will not cover vocational rehabilitation services, which are otherwise available under section 110 of the Rehabilitation Act of 1973. Therefore, the case records for individuals receiving supported employment services under the waiver will document that the consumer was denied benefits by the Division of Vocational Rehabilitation (DVR), exhausted DVR benefits (nine months is the maximum in Missouri), DVR does not cover the specific employment service the individual requires, or the person requests supports from a provider that does not participate in DVR's system. The case manager's documentation of DVR's failure to confirm a denial of benefits in writing within 30 days of verbal notification may also serve as evidence of eligibility for waived supported employment.

Supported employment services, in any combination of individual or group, is limited to \$6,000 per year per person. Any combination of supported employment services with day habilitation, respite care, personal assistant, crisis intervention, community specialist, communication skills instruction, counseling, environmental accessibility adaptations, specialized medical equipment and supplies, therapies, and transportation through the waiver shall be limited to \$20,000.

Prevocational Services

Prevocational services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in transitional sheltered workshop within one year (excluding supported employment programs).

Check one:

- _____ Individuals will not be compensated for prevocational services.
- _____ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills.

All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

h. Yes Environmental Accessibility Adaptations (Home Modification)

X Those physical adaptations to the home, required by the recipient's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the recipient would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

Environmentally accessible adaptation service is limited to \$5,000 per year, per participant. Any combination of environmentally accessible adaptation service with supported employment, day habilitation, respite care, personal assistant, crisis intervention, community specialist, communication skills instruction, counseling, specialized medical equipment and supplies, therapies, and transportation through the waiver shall be limited to \$20,000.

i. No Skilled nursing:

j. Yes Transportation:

X Other service definition (Specify):

Transportation

Transportation is reimbursable when necessary for an individual to access waiver and other community services, activities and resources specified by the plan of care. Transportation under the waiver shall not supplant transportation provided to providers of medical services under the state plan as required by 42 CFR 431.53, nor shall it replace emergency medical transportation as defined at 42 CFR 440.170(a) and provided under the state plan. State plan transportation in Missouri is provided to medical services covered under the state plan, but not to waived services, which are not covered under the state plan. Transportation

is a cost effective and necessary part of the package of community services, which prevent institutionalization.

A variety of modes of transportation may be provided, depending on the needs of the individual and availability of services. Alternatives to formal paid support will always be used whenever possible. A unit is one per month.

Transportation services, in any combination of individual or group, type or mode, is limited to \$14,000 per year per person. Any combination of transportation with day habilitation, respite care, personal assistant, crisis intervention, community specialist, communication skills instruction, counseling, environmental accessibility adaptations, specialized medical equipment and supplies, therapies, and supported employment through the waiver shall be limited to \$20,000.

k. Yes **Specialized Medical Equipment and Supplies (Adaptive Equipment and Supplies)**

X Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and supplies not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

Specialized medical equipment and supplies is limited to \$5,000 per year, per participant. Any combination of specialized medical equipment and supplies with day habilitation, respite care, personal assistant, crisis intervention, community specialist, communication skills instruction, counseling, environmental accessibility adaptations, supported employment, therapies, and transportation through the waiver shall be limited to \$20,000.

- l. No **Chore services:**
- m. No **Personal Emergency Response Systems (PERS)**
- n. No **Adult companion services:**
- o. No **Private duty nursing:**
- p. No **Family Training**
- q. No **Attendant care services:**
- r. No **Adult Residential Care (Check all that apply):**

s. Yes **Other waiver services** which are cost-effective and necessary

to prevent institutionalization (Specify): **Speech Therapy, Physical Therapy, Occupational Therapy, Behavior Therapy, Community Specialist, Counseling, Crisis Intervention, and Communication Specialist.**

Speech Therapy

Speech Therapy will be provided for consumers who have speech, language or hearing problems. Services may be provided by a licensed speech language therapist or by a provisionally licensed speech therapist working with supervision from of a licensed speech language therapist. The consumer's need for this therapy must be determined in a speech/language evaluation conducted by a certified audiologist or a state certified speech therapist. Services must be required in the plan of care and prescribed by a physician. Speech therapy will provide treatment for these and other disorders: delayed speech, stuttering, spastic speech, aphasic disorders, and hearing disabilities requiring specialized auditory training, lip reading, signing or use of a hearing aid.

This service is not available to children who are eligible for speech therapy services reimbursed under the Healthy Children and Youth (EPSDT) program.

Services may include consultation provided to families, other caretakers, and habilitation services providers. This service may not be provided by a paraprofessional. A unit of services is 1/4 hour.

Speech therapy services, in any combination of treatment or consultation, is limited to \$5,000 per year per person. Any combination of speech therapy services with day habilitation, respite care, personal assistant, crisis intervention, community specialist, communication skills instruction, counseling, environmental accessibility adaptations, specialized medical equipment and supplies, other therapies, supported employment and transportation through the waiver shall be limited to \$20,000.

Physical Therapy

Physical Therapy treats physical motor dysfunction through various modalities as prescribed by a physician and following a physical motor evaluation. It is provided to individuals who demonstrate developmental, habilitative or rehabilitative needs regarding the acquisition of skills for adaptive functioning at the highest possible level of independence.

This service is not available to children who are eligible for physical therapy services reimbursed under the Healthy Children and Youth (EPSDT) program.

Services may include consultation provided to families,

other caretakers, and habilitation services providers. Physical therapy services may not be carried out by a paraprofessional. A unit of service is 1/4 hour.

Physical therapy services, in any combination of treatment or consultation, is limited to \$5,000 per year per person. Any combination of physical therapy services with day habilitation, respite care, personal assistant, crisis intervention, community specialist, communication skills instruction, counseling, environmental accessibility adaptations, specialized medical equipment and supplies, other therapies, supported employment and transportation through the waiver shall be limited to \$20,000.

Occupational Therapy

Occupational Therapy requires prescription by a physician and evaluation by a certified occupational therapist (OT) or occupational therapeutic assistant (COTA) under the supervision of an OT. The service includes evaluation, plan development, direct therapy, consultation and training of caretakers and others who work with the consumer. It may also include therapeutic activities carried out by others under the direction of an OT or COTA. Examples are using adaptive equipment, proper positioning, and therapeutic exercises in a variety of settings.

This service is not available to children who are eligible for occupational services reimbursed under the Healthy Children and Youth (EPSDT) program. A unit of service is 1/4 hour.

Occupational therapy services, in any combination of treatment or consultation, is limited to \$5,000 per year per person. Any combination of speech therapy services with day habilitation, respite care, personal assistant, crisis intervention, community specialist, communication skills instruction, counseling, environmental accessibility adaptations, specialized medical equipment and supplies, other therapies, supported employment and transportation through the waiver shall be limited to \$20,000.

Behavior Therapy

Behavior Therapy Services provide systematic behavior analysis and assessment, behavior management plan development, consultation, environmental manipulation and training to and for individuals whose maladaptive behaviors are significantly disrupting their progress in habilitation, self direction or community integration, and/or are threatening to require movement to a more restrictive placement. Behavior therapy may also include consultation provided to families, other caretakers, and habilitation services providers. This service is intended to be of short duration. The unit of service is one-fourth of an hour.

All behavior management programs must meet and comply with the "Guidelines and Procedure for the use of Behavior Management Techniques", State of Missouri, Department of

Mental Health, Division of Mental Retardation and Developmentally Disabled. A copy of the guidelines was submitted with amendment 0178.01 and is on file with the Medicaid agency.

Behavior therapy services, in any combination of treatment or consultation, is limited to \$10,000 per year per person. Any combination of behavior therapy with day habilitation, respite care, personal assistant, crisis intervention, community specialist, communication skills instruction, counseling, environmental accessibility adaptations, specialized medical equipment and supplies, other therapies, transportation, and supported employment through the waiver shall be limited to \$20,000.

Community Specialist Services

Community Specialist Services include professional observation and assessment, individualized program design and implementation, training of consumers and family members, consultation with caregivers and other agencies, and monitoring and evaluation of service outcomes. This service may also, at the choice of the consumer or family, include advocating for the consumer and assisting him or her in locating and accessing services and supports. The provider must meet QMRP qualifications and be free of any conflict of interest with other providers serving the consumer. The services of the community specialist will assist the consumer and his caregivers to design and implement specialized programs to enhance self direction, independent living skills, community integration, social, leisure and recreational skills, and behavior management. A community specialist with expertise in person centered planning may also be selected by the consumer to facilitate the interdisciplinary planning team meeting.

The planning team shall first ensure that provision of this service does not duplicate the provision of any other services. A community specialist who facilitates the planning meeting for a person shall not have any conflict of interest with any provider who may wish to serve the person. This service is a cost effective alternative to placement in an ICF-MR. A unit of service is 1/4 hour.

Community Specialist services are limited to \$3,000 per year, per participant. Any combination of community specialist services with day habilitation, respite care, personal assistant, crisis intervention, communication skills instruction, counseling, environmental accessibility adaptations, specialized medical equipment and supplies, therapies, supported employment and transportation through the waiver shall be limited to \$20,000.

Counseling

Counseling Services include goal oriented counseling to

maximize strengths and reduce behavior problems and/or functional deficits, which interfere with an individual's, personal, familial, and vocational or community adjustment. It can be provided to individuals and families when the consumer is present with the family. This service is not available to children who are eligible for psychology/counseling services reimbursed under the Healthy Children and Youth (EPSDT) program nor to adults if a Medicaid state plan service can meet the individual's need.

Counseling includes psychological testing, initial assessment, periodic outcome evaluation and coordination with family members, caretakers and other professionals in addition to direct counseling. This service is needed by certain waiver consumers whose living arrangement, job placement or day activity is at risk due to maladaptive behavior or lack of adjustment.

The planning team ensures this service does not duplicate, nor is duplicated by, any other services provided to the consumer. Counseling is a cost effective alternative to placement in an ICF-MR. A unit of service is 15 minutes.

Counseling services, in any combination of treatment or consultation, is limited to \$5,000 per year per person. Any combination of counseling services with day habilitation, respite care, personal assistant, crisis intervention, community specialist, communication skills instruction, environmental accessibility adaptations, specialized medical equipment and supplies, therapies, supported employment and transportation through the waiver shall be limited to \$20,000.

Crisis Intervention

Crisis Intervention provides immediate therapeutic intervention, available to an individual on a 24-hour basis, to address personal, social, and/or behavioral problems which otherwise are likely to threaten the health and safety of the individual or of others and/or to result in the individual's removal from his current living arrangement.

Crisis intervention may be provided in any setting and includes consultation with family members, providers and other caretakers to design and implement individualized crisis treatment plans and provide additional direct services as needed to stabilize the situation.

Individuals with developmental disabilities are occasionally at risk of being moved from their residences to institutional settings because the person, or his or family members or other caretakers, are unable to cope with short term, intense crisis situations. Crisis intervention can respond intensively to resolve the crisis and prevent the dislocation of the person at risk. The consultation which is provided to caregivers also helps to avoid or lessen future

crises. This service is a cost effective alternative to placement in an ICF-MR.

Crisis intervention services are expected to be of brief duration (4 to 8 weeks, maximum). When services of a greater duration are required, the individual should be transitioned to a more appropriate service program such as counseling, behavior therapy, or respite. A unit of service is 1/4 hour.

Specific crisis intervention service components may include the following:

- Analyzing the psychological, social and ecological components of extreme dysfunctional behavior or other factors contributing to the crisis;
- Assessing which components are the most effective targets of intervention for the short term amelioration of the crisis;
- Developing and writing an intervention plan;
- Consulting and, in some cases, negotiating with those connected to the crisis in order to implement planned interventions, and following-up to ensure positive outcomes from interventions or to make adjustments to interventions;
- Providing intensive direct supervision when a consumer is physically aggressive or there is concern that the consumer may take actions that threaten the health and safety of self and others;
- Assisting the consumer with self care when the primary caregiver is unable to do so because of the nature of the consumer's crisis situation; and
- Directly counseling or developing alternative positive experiences for consumers who experience severe anxiety and grief when changes occur with job, living arrangement, primary care giver, death of loved one, etc.

Crisis intervention services, in any combination of professional or technician, is limited to \$5,000 per year per person. Any combination of crisis intervention with day habilitation, respite care, personal assistant, community specialist, communication skills instruction, counseling, environmental accessibility adaptations, specialized medical equipment and supplies, other therapies, transportation, and supported employment through the waiver shall be limited to \$20,000.

Communication Skills Instruction

Communication Skills Instruction Services are intended to train individuals with minimal language skills (MLS) to use systematic communication. Individuals with MLS are deaf persons who know neither English nor American Sign Language (ASL), nor have any other formal communication system.

Typically, persons with MLS were born deaf or became deaf

before they learned a language, never have spoken, and are diagnosed or labeled as having mental retardation. Through assessment and training, some will be able to learn to speak, and nearly all will be able to learn and use ASL.

This service is used to help individuals with multiple developmental disabilities communicate with the people around them, a critical skill for community survival and exercising choice and self determination.

Communication skills instruction includes both assessment/evaluation and training. An initial assessment of an individual's communication skills is performed to determine the need for instruction. It measures the number of ASL or home signs used; finger spelling capacity; degree of "parroting;" use of gesture, mime, writing on paper; attention span; facial expressions; and consistency in communication with a variety of others, both deaf and hearing. Evaluation of the outcome of the instruction occurs at six month intervals: this includes evaluation of communication skills in social, vocational and leisure situations, behavioral changes, and need for continued instruction and/or other intervention.

Communication skills instruction includes teaching a new communication system or language or enhancing a deaf individual's established minimal language skills, based on the formal assessment of communication skills. Instruction sessions typically involve the people who support the deaf individual as well as the individual himself. This service is a cost effective alternative to placement in an ICF-MR. The unit of service is one hour.

Communication skills instruction is limited to \$4,000 per year, per individual. Any combination of communication skills instruction with day habilitation, respite care, personal assistant, crisis intervention, community specialist, communication skills instruction, counseling, environmental accessibility adaptations, specialized medical equipment and supplies, other therapies, supported employment and transportation through the waiver shall be limited to \$20,000.

t. No Extended State plan services:

u. No Services for individuals with chronic mental illness:

APPENDIX B-2**PROVIDER QUALIFICATIONS****A. LICENSURE AND CERTIFICATION CHART**

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administration Code are referenced by citation. Standards not addressed under uniform State citation are attached.

SERVICE	PROVIDER	LICENSE	CERTIFICATION/ACCREDITATION	OTHER STANDARD
Personal Assistant Services	<ul style="list-style-type: none"> Employee of Consumer/Family or Employee of an Agency 			<ul style="list-style-type: none"> DMH Contract DMH Contract <i>See Appendix B-2 Addendum, Personal Assistant Services</i>
In-home Respite	<ul style="list-style-type: none"> Employee of Consumer/Family or; Employee of an Agency 			<ul style="list-style-type: none"> DMH Contract DMH Contract <i>See Appendix B-2 Addendum, In-Home Respite</i>
Out-of-home Respite	<ul style="list-style-type: none"> Community Residential Facility (CRF) or State-operated ICF/MR 	<ul style="list-style-type: none"> 9 CSR 40-1,2,4,5 	<ul style="list-style-type: none"> 9 CSR 45-5.010 certification; CARF or The Council accreditation 13 CSR 15-9.010 certification 	<ul style="list-style-type: none"> DMH Contract
Developmental Day Habilitation	<ul style="list-style-type: none"> Day Program 	<ul style="list-style-type: none"> 9 CSR 40-1,2,9 	<ul style="list-style-type: none"> 9 CSR 45-5.010 certification; CARF or The Council accreditation 	<ul style="list-style-type: none"> DMH Contract <i>See Appendix B-2 Addendum, Developmental Day Habilitation</i>
Supported Employment	<ul style="list-style-type: none"> Supported Employment 	<ul style="list-style-type: none"> 9 CSR 30-5.050 	<ul style="list-style-type: none"> 9 CSR 45-5.010 certification; CARF or The Council accreditation 	<ul style="list-style-type: none"> DMH Contract
Home Modification	<ul style="list-style-type: none"> Contractor under supervision of therapist 			<ul style="list-style-type: none"> DMH Contract Must meet applicable building codes
Adaptive Equipment	<ul style="list-style-type: none"> Adaptive Equipment 			<ul style="list-style-type: none"> DMH Contract Company registered and in good standing with the MO Secretary of State Office

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure of certification requirements are met for services individuals furnishing services that are provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

E. OTHER ASSURANCE

The State assures that State plan services that are appropriate to meet a service or support need will be accessed prior to waiver services. Waiver services will be accessed if a State plan service is not available, inappropriate to meet a person's specialized needs, or to supplement a State plan service when limitations on that service have been met.

APPENDIX B-2 ADDENDUM**DMH CONTRACT: PROVIDER REQUIREMENTS**

All waiver providers must have a Purchase of Service (POS) contract with the Department of Mental Health (DMH) for the delivery of the specific service(s) they will provide. Providers may not enroll with Medicaid as a waiver provider without first obtaining a contract with DMH. The provider must maintain a current contract in order to continue as an active waiver provider.

The DMH contract is comprehensive. It covers financially responsibility, quality of care, and the provider's obligation to protect health, safety and human rights.

QUALITY ASSURANCE

A. The Division of Mental Retardation and Developmental Disabilities (DMRDD) develops and provides services and the Office of Quality Management (OQM) is responsible for evaluating services. In addition to performing regulatory (health, safety & legal rights) certification surveys, issuing and removing certificates for agencies in the MRDD Waiver, OQM also is responsible for central office abuse/neglect investigations; audit services, outcomes evaluation, administrative hearings and appeals, regulatory process oversight, medical affairs, and disaster services. Priorities for OQM are to secure the health and safety of consumers; to ensure that treatments and supports are relevant and adequate to meet consumer need; and to ensure that consumers and their families are treated with respect and in concert with their rights as individuals.

The DMRDD is responsible for non-regulatory or enhancement components of the survey and certification process (example: community membership, relationships, & self-determination). DMRDD provides technical assistance to agencies that provide services that require certification surveys so that they can meet regulatory components of surveys conducted by OQM and for participating in the development and monitoring of enforcement plans when agencies are in Core (Regulatory) Enforcement Status. Additionally, the DMRDD is responsible for the programmatic content of the certification requirements and for related policy, training, and technical assistance.

The DMRDD's quality efforts are formally referred to as Quality Framework: Partnership for Customer-Focused Systems. "Framework" was chosen to convey the importance of having one single, statewide system. Responsibilities include:

- Policy development related to quality assurance;
- Track & monitor correction of all core issues identified by OQM during surveys;
- Direct involvement with regional centers in correction of severe, pervasive core issues;
- Promote and monitor the Quality Outcomes. (Quality Outcomes specifies the DMRDD's expectations regarding outcomes for people who have developmental disabilities who are supported by the DMRDD system);
- Training and technical assistance; and
- Self-determination activities, for example, rights brochure and presentations.

B. The DMRDD's 11 regional centers have Quality Improvement (QI) teams that visit each provider when an agency is to be certified. A member of the QI team also accompanies OQM staff on surveys within the

region. Each team has at least one nurse. Each regional center team is part of DMRDD's Quality Framework. The teams are responsible for looking for outcomes in accordance with Quality Outcomes and for working with providers to develop enhancement plans. When an enhancement plan is developed, the QI team reviews progress with the provider periodically, but no less than once per year.

If a provider refuses to cooperate in taking corrective action by working on an enhancement plan, regional centers can initiate intermediate sanctions such as discouraging new admissions or encouraging the development of new providers in the area. Also, regional centers can formally request the DMH OQM survey team or the accrediting agency (CARF or The Council) review an agency, can institute audit procedures concerning fiscal and contract compliance, and can remove individuals from services and terminate a provider's DMH contract if necessary.

The Division of MRDD follows statewide procedures, established in statute and regulation, for reporting and investigating complaints of abuse, neglect and misuse of funds/property in residential, day programs or specialized services licensed, certified or funded by the Department of Mental Health. Reports of these incidents and other types of incidents are reported to the Division of MRDD local regional centers that administer the waiver. Division of MRDD Central Office staff as well as staff at the Department level, Office of Quality Management, monitor to ensure appropriate action is initiated and completed.

CONSUMER INCIDENTS

The Division of MRDD has a statewide process for receiving, reviewing and tracking consumer incident reports. The regional center is responsible for taking appropriate follow-up action with the provider of services to ensure the health, safety, rights, and quality of services to consumers. The incident management process includes a statewide automated database for incident tracking, resolution, action planning and trend analysis. The Division of MRDD and each regional center consider trend data to make changes at the local and state levels for quality improvement of the services delivery system. The automated system is being enhanced. When the enhancements are completed, provisions will be made to transfer data to the State Medicaid Agency.

STATEWIDE BACK-UP SYSTEM

Case management is provided by the Division of MRDD'S 11 Regional Centers. Each has a regular and toll-free phone number that is available to the general public, including persons in service and provider agencies. Each Regional Center has responsible, management or supervisory level staff on-call each evening and weekend. When phone calls are placed to a Regional Center after hours, the caller is given a pager number to call. The call is immediately returned. The person taking the call resolves the issue or contacts other staff at the regional center as may be necessary to resolve the issue. Each Regional Center also has a crisis team. Depending on the nature of an after hours contact, the Regional Center might send in staff from the crisis team to provide temporary services. A system to notify the State Medicaid Agency of events that impact participant health and safety is being developed.

b. _____ Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1) _____ A special income level equal to:

_____ 300% of the SSI Federal
benefit (FBR)
_____ % of FBR, which is lower than
300% (42 CFR 435.236)
\$ _____ which is lower than 300%

(2) _____ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program.
(42 CFR 435.121)

(3) _____ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435.324.)

(4) _____ Medically needy without spenddown in 209(b) States, (42 CFR 435.330).

(5) _____ Aged and disabled who have income at:

a. _____ 100% of the FPL
b. _____ % which is lower than 100%.

(6) _____ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7. _____ Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8. **X** Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.) Sections 1902 (1), 1905 (n) and 1925 of the Social Security Act.

ADDENDUM TO APPENDIX D-3**b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT****Evaluation of Level of Care**

Before a person enters the waiver, a regional center casemanager (who is a QMRP or under the direct supervision of a QMRP) gathers collateral information and assures that social history and medical information is current. The casemanager also ensures that results of any testing or previous habilitative program experience is summarized, and that any additional professional assessment necessary for determining level of care or program planning is requested. The casemanager then completes a functional screening instrument designed to provide general information on what a person with developmental disabilities can and cannot do and lists any types of adaptations and supports which are in use.

The Missouri Critical Adaptive Behaviors Inventory (MOCABI) is the instrument used for adults and for children when appropriate. Regional centers determine other age appropriate instruments such as the Vineland that will be used for younger children. Based on the MOCABI, Vineland, or other appropriate instrument, and on observation, interviews, collateral information and assessments, the casemanager documents that the person has mental retardation and/or a developmental disability which meets the federal definition of a "related condition", that the person has limitations which would require active treatment in an ICF-MR and, explains why the person is at risk of entering an ICF-MR.

Based on this documentation, the individual may be admitted into the waiver. This process is analogous to the initial level of care assessment performed for the ICF-MR program using Department of Health and Senior Services forms DA-124 a/b, but is more appropriate to the assessment of persons with developmental disabilities.

Functional Assessment and Plan of Care (Person Centered Plan)

No later than 30 days from the date of acceptance into the waiver program, an interdisciplinary planning team will develop a person centered plan for the individual. This plan will be in accordance with Quality Outcomes of DMRDD. It will be based on the casemanager's functional assessment of the individual, all other assessments that are pertinent, and the observations and information gathered from the members of the team. The functional assessment will determine how the individual wants to live, the individual's routines, what works for the individual and what doesn't. It also assesses what the individual wants to learn and how the individual learns best. It measures how independently the individual functions and what interferes with what the individual wants, and it suggests ways the individual's needs and wants can be met.

The plan will specify all the services and supports that will be needed, and who is to provide them, to enable the individual to live the way (s)he wants and learn what (s)he wants. These methods may include teaching, which does not have to be behavioral; it can be incidental learning, so long as it is planned. Providing supports or making adaptations to the environment may be part of the plan. The plan will also specify any limitations the planning team foresees in being able to support the individual in achieving these desires. Such limitations can be financial, temporal (not everything can always be done in the immediate future, so we need to prioritize), and/or can relate to health and safety. If the individual already has a person centered plan, the team will update that plan.

The interdisciplinary planning team will include the individual and his representatives, family or guardian. The individual will choose whom (s)he wants to attend as a member of the team, unless (s)he is a minor or has been judged incompetent, in which case the family or guardian must attend. The team will also include a casemanager and providers selected by the individual and other professionals involved with the individual may be included as

applicable and at the individual's invitation. The case manager and individual and/or his/her representative will sign the completed plan. All members of the planning team will be provided a copy of the completed plan as appropriate. Plans of care must be approved by DMRDD. DMRDD will determine the effective date of the plan, however, this shall be no earlier than the date of the interdisciplinary planning meeting.

All person centered plans are subject to DMRDD utilization review/approval process. The purpose of the utilization review/approval process is to:

- Enhance quality of services and the service delivery system;
- Ensure fairness and consistency statewide;
- Ensure accountability for taxpayer dollars; and
- Stretch limited MRDD resources.

Case managers are responsible for ensuring service limitations are not exceeded during planning and authorization processes. When the plan of care is developed and approved, the authorized services and costs are set-up in the Division of Mental Retardation and Developmental Disabilities' automated system. The system is capable of calculating the annual cost of a single service and a total of all services on the plan of care. If a case manager finds it necessary to increase or decrease services, the changes will also be made in the system. This system will be used to monitor whether a limit has been met.

If a case manager determines a participant has increased needs, the case manager will propose a change to the plan. The changed plan will be subject to utilization review. The utilization review committee may approve or deny the changes, or may recommend alternative solutions. If increased services are denied, the person will be advised in writing, and will be provided information on appeal rights.

If the proposed change to the plan will cause a service limitation to be exceeded but the service is deemed necessary to protect the person's health and safety and/or prevent the person from entering an institution, an exception can be requested. Exceptions may be approved by the Division of MRDD Director, or a designee, for a one time expense, or during a crisis, or a transition period.

Individuals participating in the waiver will not lose eligibility for the waiver due to an increased need for a covered service that causes the total need for that service or combination of services to exceed maximum amounts established by the state.

Examples of action the planning team may take to assist the person in accessing additional services that are required for health and safety and to avoid institutionalization are:

- Seek additional natural supports;
- Consider accessing non-waiver State or County (local) funds;
- Request approval for an exception from the Division of MRDD Director or designee, to exceed a maximum limitation for a one-time expense, or during a crisis or transition period; and/or
- Provide the person information regarding other Missouri waivers such as the MRDD Comprehensive waiver and provide assistance with applying and transitioning as needed.

If it is determined that the individual's health and welfare cannot be assured in the community by any or a combination of the above actions, the State may find it necessary to discharge the person from the waiver and may recommend institutional services.

Reevaluations of Level of Care

Casemanagers reevaluate each recipient of waived services annually for continued need of an ICF-MR level of care. The reevaluation includes the updating of all assessments on which the previous evaluation was based, including the MOCABI, and redocumentation of conditions of eligibility as listed above.

The standard form for Level of Care Evaluations and the MOCABI instrument follow.

APPENDIX E-2**a. MEDICAID AGENCY APPROVAL**

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency: **The Medicaid agency selects a minimum sample of 25 waiver plans of care per year. This review by staff from the State Medicaid Agency ensures individuals receiving waived services had a person centered plan in effect for the period of the time services were provided. The review process also ensures that the need for services that were provided was documented in the plan, and that all service needs in the plan were properly authorized prior to delivery.**

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.
2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

